II. REFERRAL FUNCTIONS

The contractor, using Health Care Finders and PCMs, is responsible for coordinating referral functions for all Military Health System (MHS) beneficiaries. The TRICARE Prime program requires that specialty and *inpatient* services be accessed by enrollees only upon referral by a PCM and with authorization by the Health Care Finder or other contractor designee except in the case of medical emergencies, outpatient mental health services referenced in Section II.A.1.a.(1) of this section, *clinical preventive services (Policy Manual Chapter 12, Section 8.1)*, and the use of the Point of Service option.

A. Health Care Finder

The contractor shall establish and maintain, in all areas with TRICARE Service Centers, Health Care Finder functions to facilitate referrals of beneficiaries to military and civilian health care services. The contractor shall provide a staff of Health Care Finders to ensure that referral services are available at all times through a TRICARE Service Center with no more than a fifteen (15) minute wait for beneficiaries visiting the TRICARE Service Center. The telephone blockage rate at each TRICARE Service Center shall not exceed five percent (5%), and beneficiaries telephoning the TRICARE Service Center shall never be placed on "hold" for more than five (5) minutes. Additionally, the contractor shall provide Health Care Finder services through a nationally accessible toll-free number. The contractor shall continuously staff all incoming toll-free Health Care Finder lines 24-hours per day, 7-days-a-week with qualified Health Care Finders. (See OPM Part Three, Chapter 4, Section VI.B. for toll-free line standards and requirements.) The toll-free line operation may be centralized in one or more locations.

1. Health Care Finder Functions

The Health Care Finders shall perform the following principal functions:

a. Facilitate Referrals

The contractor shall establish referral mechanisms to ensure optimal utilization of MTF facilities and resources and to foster coordination of all care delivered in the civilian sector and care referred to and from the MTFs. The contractor shall contact the MTFs to determine capacity before recommending or authorizing care with civilian providers. The referral-facilitation services of the Health Care Finders are primarily for ensuring access to care for enrolled beneficiaries; however, nonenrolled beneficiaries are encouraged to use the Health Care Finder functions to find care in the network under TRICARE Extra. [(Nonenrollees are required to seek authorizations from the Health Care Finder prior to an NAS being issued (Section II.A.1.b. of this section)]. When space is not available in the MTFs, Medicare-eligible beneficiaries can use the Health Care Finder to access providers who accept Medicare assignment. Referrals shall be processed on CHCS (when required by contract).

(1) Referral to Primary Care

Enrolled beneficiaries must initially obtain *most health* care services from their *PCMs* or have their *claims* adjudicated in accordance with the Point of Service provisions (TRICARE/CHAMPUS Policy Manual, Chapter 12, Section 10.1). Enrollees may seek outpatient mental health services through their PCMs, or they may self-

refer to a network mental health provider for the first eight (8) visits. In those cases where an enrollee self-refers, the contractor shall ensure that the network mental health provider obtains an authorization from the Health Care Finder for services rendered. This authorization is only to ensure that claims are processed appropriately and is not a prospective review as defined by OPM Part Three, Chapter 3, Section I. For all beneficiaries, outpatient mental health care beyond the eighth (8th) visit shall be prospectively reviewed for medical necessity. For nonenrolled beneficiaries who initially contact the Health Care Finder at the TRICARE Service Center or by telephone, the contractor shall maintain mechanisms to facilitate referrals to care. These mechanisms shall be made available to the Lead Agents. In catchment areas containing more than one MTF, the contractor shall, after consultation with the Lead Agents and the MTF Commanders and in accordance with DoD policy, establish mechanisms to ensure that: (1) all MTF resources in the area are considered before recommending or authorizing care with civilian providers (determinations on MTF referrals shall be subject to travel distances to the MTF where services are available for patients with consideration given to the nature of the medical problem); and (2) coordination is maintained among the respective TRICARE Service Centers. All network mental health providers shall agree to provide TRICARE Prime beneficiaries' PCMs with a report of the treatment rendered if the beneficiary authorizes the release of the information.

(2) Referral to Specialty and Inpatient Services

The contractor shall establish referral procedures to ensure access to specialty and inpatient health care services for all MHS-eligible beneficiaries, especially enrollees.

(a) The Health Care Finder shall assist the PCM in facilitating specialty and inpatient referrals for care available in the MTF or, if not available (or not available within a medically appropriate time period), to a provider within the contractor's network except in those cases where, for a Prime enrollee with an MTF PCM, the MTF has determined, after consultation with the contractor, that the care required could be provided more cost-effectively by a non-network provider.

(b) If services are not available, or not available within the medically appropriate time period from a provider in the contractor's network, the contractor shall arrange for care with a provider outside the contractor's provider network. Contractors shall apply Prime provisions to claims for referred and authorized care received by prime enrollees from non-network providers. Contractors shall ensure that referring network providers and Health Care Finders follow established referral/authorization procedures in order to avoid the inappropriate application of Point of Service cost-sharing to claims for referred/authorized care received by Prime enrollees from non-network providers.

NOTE:

Effective with care received on or after March 16, 1998, on claims for Prime enrollees receiving emergency or referred/authorized care from non-network, non-participating providers, the TRICARE reasonable charge will be the lesser of the following amounts: (1) the billed amount or (2) the CMAC level plus any balance billing amount up to the balance billing limit (115 percent of the CMAC level). Enrollees shall pay only the Prime copayment. Refer to Policy Manual Chapter 12, Section 2.1, for information on claims for certain ancillary services. Contractors need not review past claims for those processed under

obsolete requirements. If, however, it is brought to a contractor's attention that a claim was processed according to previous requirements and the date of service is on or after March 16, 1998, the contractor shall adjust the claim according to the new requirements.

(c) The contractor shall ensure that TRICARE Prime enrollees receive care from network providers and shall authorize the use and services of each non-network provider involved in referred care including institutions that use consultants or other non-network providers. MTFs may refer their Prime enrollees to a non-network provider who is determined to be less costly or in instances where there are no clinically appropriate network providers. The Health Care Finder shall facilitate the referral. Referrals shall be processed on CHCS (when required by contract).

b. Authorizations

(1) For Prime enrollees, all specialty and inpatient medical care not provided by the PCM except emergencies, outpatient mental health services referenced in paragraph a(1) above, clinical preventive services supplied by network providers (TRICARE/CHAMPUS Policy Manual, Chapter 12, Section 8.1), and services obtained under the Point of Service option must be referred from the PCM and authorized by the Health Care Finder or other contractor designee. This requirement is applicable for services referred to the MTF when the enrollee has been assigned a PCM in the network or for services referred to a provider outside the MTF when the enrollee has been assigned an MTF PCM.

NOTE:

Nonenrolled beneficiaries are not required to obtain authorization for care from the Health Care Finder except when an NAS is required. Providers serving nonenrollees shall comply with the prior authorization requirements established under OPM Part Three, Chapter 3, Section I.B.3.b.

(2) The Health Care Finder authorization functions shall include first level review of all referrals for medical necessity, for those admissions and procedures that require preauthorization, as outlined in OPM Part Three, Chapter 3 and Chapter 5. Also, the review will include the determination that care was referred from the PCM. In addition, MTF commanders may give Health Care Finders written authorization to perform the authorization functions for referrals from MTF PCMs to other MTF providers. MTFs that desire contractor support for this provision are identified in OPM Part Three, Chapter 5.

c. Nonavailability Statements (NASs)

MTF Commanders may give Health Care Finders written authorization to issue Nonavailability Statements (NASs) on their behalf, and the contractor shall perform these functions in accordance with DoD NAS requirements (See DoD Instruction 6015.23, as implemented by TRICARE/CHAMPUS Policy Manual, Chapter 11, Section 2.1. and OPM Part Two, Chapter 1, Section IV.G.). Such authorizations shall be by mutual consent of the contractor and the MTF commander. Specific policies and procedures shall be addressed in the MOU between the contractor and the MTF Commander. Health Care Finders shall coordinate all NAS requirements with MTF Health Benefits Advisors. (If the NAS issuance function is retained by MTF personnel, they shall coordinate the NAS

issuance closely with the Health Care Finder in order to ensure that the appropriate clinical review is accomplished before issuing an NAS.)

(1) For nonenrollees, after a determination is made that care cannot be provided in an MTF and prior to issuing an NAS, the contractor shall review the request to determine the medical necessity of the requested medical service. Requirements for determining clinical necessity are established in OPM Part Three, Chapter 1, Section II.A.1.c.

(2) When authorized by the MTF Commanders, Health Care Finders shall consider the availability of services from MTF providers, in deciding whether to issue an NAS. If the care that is determined medically necessary is not available in the MTF, then an NAS will be issued. (See TRICARE/CHAMPUS Policy Manual, Chapter 11, Section 2.1 which contains DoD Instruction 6015.23, "Delivery of Healthcare at Military Treatment Facilities (MTFs)"; and OPM Part Two, Chapter 1, Section IV.G.)

(3) When the care is found to be medically necessary, but the beneficiary is denied an NAS because the care is available at an MTF, and the beneficiary is not satisfied with the decision, the beneficiary's only remedy is to seek an administrative review from the MTF commander in accordance with DoDI 6015.23.

(4) *For nonenrollees, when the issuance of an NAS is denied because the care is found not to be medically necessary, and the beneficiary is not satisfied with the decision, the beneficiary may appeal the decision under the appeals process set forth in OPM Part Three, Chapter 7.*

d. Other Functions

The Health Care Finders shall inform beneficiaries of access mechanisms, referral procedures, and rules regarding use of providers. They shall also improve patient continuity of care by establishing mechanisms to facilitate necessary consultations, follow-up appointments, and the sharing of medical records (see OPM Part Three, Chapter 5).

2. Qualification of the Health Care Finders

Health Care Finders who perform the first level review functions as part of the authorization process for medical and surgical referrals shall be qualified physicians, registered nurses or physician assistants. In cases of mental health services, the contractor shall use licensed psychiatric nurses or other mental health professionals. Qualification requirements are further stated in OPM Part Three, Chapter 3, Section I.A.4. Health Care Finders who perform duties such as appointing and scheduling, that do not require clinical judgment, may have administrative or clerical qualifications.

B. Specialty and Inpatient Care

In each catchment area, the MTF is the first choice provider for all nonemergency specialty and inpatient care for the TRICARE program unless otherwise indicated by the MTF Commander. The contractor is responsible for coordinating the referral function for both beneficiaries and network providers through administration of a Health Care Finder program (Section II.A. of this section). If services are not available at the MTF, the beneficiary shall be referred to the contractor's network through Health Care Finders. If the required care is not available in the network, the health care finder shall arrange for care

through a nonnetwork provider. The contractor shall ensure that all specialty and inpatient care for enrollees, whether provided in the MTF or in the civilian network, has been authorized.

C. Specialized Treatment Services (STSs)

The Assistant Secretary of Defense for Health Affairs [ASD(HA)] designates Specialized Treatment Service (STS) facilities. These facilities shall be considered the preferred facilities for all MHS beneficiaries for the particular speciality services offered. These facilities take precedence for specialty care referrals for all TRICARE patients to the extent that they are available (see OPM Part Two, Chapter 24).

VI. SERVICES DEPARTMENT

A. General

The contractor shall make timely, accurate answers to all TRICARE inquiries [written, telephone, walk-in, ASD(HA), TRICARE *Management Activity (TMA)*, Lead Agent, HBA, and congressional].

1. Correspondence Receipt and Control

The contractor shall establish and maintain a control system for routine and priority correspondence, appeals, and grievances which meets the requirements of OPM Part One, Chapter 1, Section III.E.; *OPM Part Two, Chapter 8;* and OPM Part Three, Chapter 7. The contractor shall capture and retain needed data for input to workload and cycle time aging reports. The correspondence control system shall be automated.

2. Availability of information

Information required for appropriate response to inquiries, including but not limited to TRICARE claim files, appeal files, previous correspondence, and canceled checks must be retrievable within five (5) workdays following a request for the information.

3. Filing

All documents received or generated in the services department as a result of responding to correspondence, handling of appeals, or in other actions shall be filed within five (5) workdays following processing to completion. (See the OPM Part One, Chapter 2 and OPM Part Two, Chapter 8, Section II.A. and B.)

B. Telephones

1. General

The requirements and standards established below apply to all toll-free telephone calls. There should be no differentiation in the service provided whether the call originates locally or through the toll-free lines. The contractor shall provide the availability of telephone contact as a service to all TRICARE inquiries [beneficiaries, providers, ASD(HA), *TMA*, HBAs, and congressional offices]. The service must be continuous during normal business hours which are defined as 8:00 A.M. through 6:00 P.M. (except weekends and holidays) in all time zones within the region. This service is intended to assist the public in securing answers to various TRICARE questions including, but not limited to:

a. General program information;

b. Specific information regarding claims in process and claims completed, e.g., explanations of the methods and specific facts employed in making reasonable charge and medical necessity determinations, information regarding type of medical services submitted;

c. Additional information needed to have a claim processed;

d. Information about review and appeal rights and the actions required by the beneficiary or provider to use these rights.

e. Information about and procedures for the TRICARE Program.

f. Information concerning benefit authorization requirements and procedures for obtaining authorizations. Provisions must be included to allow the transfer of calls to the authorizing organization (within the contractor's organization, to include subcontractor) without disconnecting the call.

g. Providing, via a separate toll-free telephone number within each Region, information to all MHS beneficiaries about *TRICARE* participating providers in their location, especially for those beneficiaries living in remote areas without access to the contractor's network providers. The telephone service shall be available for the same amount of time and under the same standards as required in Section VI.B. of section.

(1) When contacted, the contractor shall provide the beneficiary with the name and telephone number of at least one TRICARE-authorized provider in the desired speciality, if one is available, who has participated on TRICARE claims within the previous calendar year or who has committed to participate on future TRICARE claims. The contractor shall inform the beneficiary that, although the provider has participated in the past, the provider is allowed to participate on a claim-by-claim basis; therefore, the beneficiary should contact the provider to see if he/she is willing to participate. The contractor shall also offer to contact the provider on behalf of the beneficiary. The contractor shall attempt to locate a participating provider that is close to the beneficiary's residence, but no more than sixty (60) minutes travel time unless the beneficiary waives the sixty (60) minute requirement. No written follow-up notification is required when a response is possible during the initial telephone call.

(2) If the contractor cannot find a provider within the travel distance who has participated in TRICARE in the past or who has committed to providing medical care on a participating basis, the contractor shall offer to contact local providers on behalf of the beneficiary to locate a provider willing to participate. Providers who have previously declined participation within the prior calendar quarter need not be contacted. The contractor shall contact a minimum of three providers practicing within the 60 minute travel limit radius of the beneficiary's address. (The three provider limit is waived if there are not three providers available within the required distance who will participate.)

(3) Within five (5) working days of the initial request for assistance in finding a participating provider who has not already been identified, the contractor shall telephonically notify the beneficiary of the results of the search. The contractor shall make a minimum of three (3) attempts to contact the beneficiary by telephone. In addition, the contractor shall send a written notification to the beneficiary within the same five (5) working days. The written notice shall include the following:

(a) The names, addresses, and telephone numbers of all the providers contacted with an indication of who will participate, if any, on TRICARE claims.

(b) If the contractor is unable to locate a participating provider, the beneficiary shall be provided information on the one hundred fifteen percent (115%) balance billing limitation and the ability to request a waiver of the balance billing limitation. The contractor shall inform the beneficiary of the procedures required to request a waiver.

(c) The beneficiary shall be informed of his/her right to take the notification to a nonparticipating provider in order to inform the provider of the legal restrictions on balance billing.

2. Telephone Standards

The following performance standards shall apply to all toll-free telephone calls:

a. Eighty percent (80%) of all calls shall be acknowledged within twenty (20) seconds by an individual or electronic device.

b. Ninety percent (90%) of all calls must be handled by a telephone representative or automated response unit (ARU) within 120 seconds after acknowledgment. During any delay, a message must inform the caller of the temporary delay and give advice about what information is needed to answer questions. Eighty (80) percent of the calls must be handled to completion during the initial call. A completed call is one in which the caller is given all the information they need to know regarding the situation about which they are inquiring.

c. If the call is not completed, the call-back must be made within two (2) working days. The call must be kept under control to assure that the required call-back is made. If it is impossible to provide a final reply, an interim status call must be made within two (2) working days. For all calls not answered with two (2) days, a final call-back or written reply must be provided to ninety-five percent (95%) within ten (10) calendar days and one-hundred percent (100%) within twenty (20) calendar days.

d. The contractor shall measure the quality of service by each telephone representative on a monthly basis for accuracy, responsiveness, clarity and tone. Each telephone representative is to be monitored on a sample basis equal to three (3) percent of the average daily calls handled, but not fewer than ten (10) calls per day. The sample calls do not have to be monitored from start to finish but must be monitored sufficiently to determine the adequacy of the representative's actions.

3. Toll-free Telephone Service

Toll-free service can be provided by a number of means available from local telephone companies. These include, but are not limited to: Wide Area Telephone Service (WATS), Foreign Exchange lines (FX), etc.

a. Contractors are not restricted to the use of any long distance carrier and may change companies at their discretion to improve the efficiency and cost effectiveness of the toll-free service. Should changes in long distance carriers occur, these changes must be transparent to the TRICARE beneficiaries and providers. The Contracting Officer shall be notified of any proposed change in companies at least thirty (30) calendar days prior to the actual change of companies.

b. The contractor shall advertise the toll-free service using all available media including the Explanation of Benefits (EOB); newsletters; telephone directories published by the contractor, military organizations, etc. and other appropriate sources.

4. Telephone Monitoring Equipment

The contractor or telephone company with which the contractor does business shall have telephone equipment that:

a. Measures busy signal level. Busy signal level is defined as the percentage of time a caller receives a busy signal. The equipment must produce busy signal data. The busy signal rate shall be expressed as a percentage, which is to be determined as follows: divide the number of calls answered by the contractor by the number of calls reaching and attempting to reach the contractor (must be machine generated figures). The contractor shall ensure that the busy signal rate never exceeds twenty percent (20%).

b. Ensures that eighty percent (80%) of all calls are acknowledged within twenty (20) seconds. Telephone equipment must be programmed to ensure this standard is always met. This level of service shall be available at all times - daily, weekly, monthly, etc. Averages are not acceptable.

c. Measures the number of calls received each month in which the time elapsing between acknowledgment and handling by a telephone representative or ARU (waiting time) is one hundred-twenty (120) seconds or less. Includes all calls that are directly answered by a telephone representative or ARU (no waiting time). The one hundred-twenty (120) second time period begins when the telephone call is acknowledged and does not include the twenty (20) second ring time.

5. Additional Equipment Requirements

The contractor shall furnish the following:

a. Access to a CRT for each telephone representative to retrieve or provide the information required in Section VI.B.1. above. The CRT shall be located to allow the telephone representatives to research data without leaving their work stations.

b. Outgoing lines sufficient to allow call backs.

c. Hard copy management reports regarding All Trunks Busy (ATB) data and the twenty (20) second and one hundred-twenty (120) second waiting time measurement. The hard copy management reports shall also include the total number of calls received, the number answered at the time of the call, the number fully answered within two (2) working days, the number fully answered within ten (10) calendar days, the number fully answered within twenty (20) calendar days, and the percentage of each.

d. A supervisor's console to monitor telephone representatives' telephone calls for accuracy, responsiveness, clarity, and tone.

e. Automatic call distributors and automatic response units (ARUs) with after hour message recorders, an automated, interactive, 24 hour call-handling system designed to ensure maximum access to the toll-free lines. This system shall provide automated responses to requests for general program information and to beneficiary requests for claims status.

Appeals and Hearings

Chapter 7

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